Influence of the Background of Hospital Directors on the Decision Making Process – Outsourcing of the Sterilization into a Public-Private Partnership

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SUMMARY

Title: Influence of the Background of Hospital Directors on the Decision Making Process – Outsourcing of the Sterilization into a Public-Private Partnership

Background: Since the beginning of health care system, it was normal that physicians should be in managerial positions. This approach is called clinical leadership and is defined when staff with medical background takes a leading post and influences strategic decisions and resource allocation. A change of organizational structures was brought through new public management (NPM) where management became a profession in itself and the responsibility for medical treatment was disconnected from management. Due to this, it was possible to take leading managerial positions for persons with non-medical background.

Aim: The top management of the hospital Feldkirch in Austria gets examined how it has taken decisions and how important the professional background is. Special focus will be laid on the process of the outsourcing of the hospital's own sterilization into a public-private partnership (PPP).

Methods: The study uses a literature review on the historical perspective of management structures in hospitals and on management/leadership key points, an expert interview and written materials (e.g. protocols, annual reports) to check and back up the findings of the interview.

Conclusion: The managerial function are crucial for a successful project and it takes time to learn and develop the essential skills for management. When taking on a managerial position the professional background does not play a too important role. Little attention is given to nurses in managerial positions. The PPP was implemented due to the expertise, the problem sharing and responsibility of the partner while disadvantages like the distance, higher service costs and complexity of the tender were mitigated.

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Thank you

DECLARATION IN LIEU OF OATH

"I hereby declare, under oath, that this master thesis has been my independent work and has not been aided with any prohibited means. I declare, to the best of my knowledge and belief, that all passages taken from published and unpublished sources or documents have been reproduced whether as original, slightly changed or in thought, have been mentioned as such at the corresponding places of the thesis, by citation, where the extent of the original quotes is indicated.

The paper has not been submitted for evaluation to another examination authority or has been published in this form or another."

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ACRONYMS

GDP gross domestic product 1

KAKuG Bundesgesetz über Krankenanstalten und Kuranstalten, StF: BGBl. Nr. 1/1957 NR: GP VIII AB 164 S. 22. BR: S. 121 6

KHBG Vorarlberger Krankenhaus-Betriebsges.m.b.H. 2

NHS National Health Service 5

NPM new public management iv

PPP public-private partnership iv

SpG. Gesetz über Krankenanstalten (Spitalgesetz), Vlbg LGBl.Nr. 54/2003 6

MPAV Medizinprodukteaufbereitung Vorarlberg GmbH 32

1 BACKGROUND AND RESEARCH QUESTION

1.1 Introduction

Since the beginning of health care system, it was normal that physicians should be in managerial positions. This approach is called clinical leadership and is defined when staff with medical background takes a leading post and influences strategic decisions and resource allocation (Malby, 1998; Edmonstone, 2009; Swanwick and McKimm, 2011). As well as in the Professional Bureaucracy with its parallel administrative hierarchies, namely the top-down bureaucracy and the bottom-up approach for professionals (Mintzberg, 1983), Edmonstone (2009) states that clinical leadership focuses only on a small patient group while the managerial leadership has an overall view of the organization and the whole patient population.

During the last decades a rapidly increase of the health care costs could be seen all across Europe. In the European Union as well as in Austria the total expenditure on health measured against the gross domestic product (GDP) has risen in 1970 from 5,1% (Huber, 1999) and 5,16% respectively to 9,5% and 10,98% respectively in 2010. (*Factbook*; *Health policies and data*)

The NPM approach emerged out of the need for efficient hospitals and good services. NPM focuses on outcomes as well as how management can increase the efficient use of public budgets (Hood, 1991; Schedler and Proeller, 2006; Aristovnik and Seljak, 2009). A change of organizational structures was brought through NPM where management became a profession in itself and the responsibility for medical treatment was disconnected from management (see especially section 2.1, p. 4). Due to this, it was possible to take leading managerial positions for persons with non-medical background. (Glouberman and Mintzberg, 1998; Jespersen and Wrede, 2009)

1.2 Research Question

The state hospital Feldkirch in the Austrian state Vorarlberg evolved out of the „Medizinische Zentrum Feldkirch", which was founded 1972 and consisted of the hospital of the city of Feldkirch and the state accident hospital (Landesunfallkrankenhaus). Finally, in 1979 the two hospitals were merged. Already two years later an administrative director took over and brought the second most expensive hospital in Austria into the most favorable third. The executive manager of the Vorarlberger Krankenhaus-Betriebsges.m.b.H (KHBG) Dr. Fleisch states that, *"today the LKH Feldkirch has in no way to be afraid to be compared"*. (*Landeskrankenhaus KHBG - Portal*)

However, the state hospital Feldkirch can be used as an example to find out how the top management in the health care sector runs their hospitals (e.g. how is it to manage senior physicians, but also head nurses), especially during an important (strategic) decision making processes.

With a case study the top management of the hospital in Feldkirch gets examined how it has taken decisions and how important the professional background is. Special focus will be laid on the process of the outsourcing of the hospital's own sterilization into a PPP. The reason for choosing this project is that it can be used as an example to see the whole process involved to get to a decision and how the medical professions were handled during this specific project.

1.3 Data and Method

The first task will be a literature review on the historical perspective of the management structure in the hospitals and on management/leadership key points that influence the decision making process. The research question aims at describing a social institution, therefore the used approach to answer the question will be a qualitative one. When decision makers are asked about a specific topic, in-depth interviews are the best option. Through the semi structured and open questions, the study composer can steer and control the interview, by which means the interviewer gets a full understanding of the taken decisions of the top managers. The interviewees are the administrative and eventually medical and nursing directors. In addition a content analysis

of written materials (e.g. protocols, documents of projects, annual reports, e-mail conversations and committee minutes) will be used to situate the directors in time and in the current organizational settings and to check and back up the findings of the expert/elite interviews. (Berg and Lune, 2012) Motivated by incomplete knowledge this will help to understand how the top management in hospitals and the administrative director in particular manages the hospital and medical professions, respectively. Additional insight can be found which influences and developments can lead to a successful or failed outsourcing of a hospital department into a PPP.

2 TRANSITION OF THE HOSPITAL MANAGEMENT

2.1 Analysis of Hospital Management in England - The National Health Service (NHS)

The management of voluntary hospitals at the end of the 19th century consisted of the chairman of the medical committee, the matron who was head of nursing and responsible for the training of nurses and the house governor, who was in charge of the clerical staff and the finance. This tripartite management worked together, although tensions arose because each focusing only on their respective fields. This led to the administrators role of mainly coordinating, implementing, problem solving and fund raising (in the 1930s). A different management situation was given within municipal hospitals where a medical superintendent was superior to both the nurses and the lay staff. Alderman Bradbeer was commissioned to have a look on the hospital internal administration (Edwards, Linton, and Potter, 1993; Baly, 1995). His recommendations in 1954 are that the matron is accountable to the governing body, but only regarding to nursing itself and the training of nurses. For all other duties besides this two she reports directly to an administrative officer (Bradbeer, 1954; cited in: Baly, 1995). The decision making process was bureaucratic and time consuming due to a high amount of committees at all levels. Administrators needed approval even for routine tasks like getting more linen. Another reason why it took so long to reach a decision was the used management style at this time. Consensus was needed within the multidisciplinary team and resulted often in unfavorable compromises. This bad, shared or lack of leadership was one of the main reasons why the quality of some hospitals in the NHS was so poorly and inconsistent during the 1960s. The ensuing issue of weak managerial leadership called on the one hand for action and on the other hand to address the questions where the

boundaries lie between professional and managerial as well as team and individual responsibility. (Edwards, Linton, and Potter, 1993)

Griffith's strong suite was his business experience and after analyzing the NHS he came up with following general observations. The management differences of the NHS compared to businesses get overrated, but it is the similarities that need consideration. In both enterprises middle management deals with the same tasks, e.g. the quality of service or product, cost containment by meeting budgets, R&D and HR management, which have to be controlled to meet predefined key figures. This evaluation of performance measures is insufficient within the NHS. A major issue is that a general management function (see section 3.1, p.7) is insufficiently defined. Where such a management is provided it is undermined either by time issues of the senior staff or by consensus management, which left the administering of the general management throughout the NHS behind its need and potential. Implications are that no prime mover takes on responsibility for working on the management functions, that no direction is given, that staff motivation declines and that a lack of responsibility and accountability makes change almost impossible. Griffiths (1983, p.12) summarizes the management problem with his well known statement that *"If Florence Nightingale were carrying her lamp through the corridors of the NHS .. she would almost certainly be searching for the people in charge."* He did not only had a look on the current situation but recommended actions on management by keeping in mind that the National Health Service (NHS) has to take various interests into account (patients, population as payers, staff). The immediate implementation of this actions is important. The key task of a small and general management at the heart of the NHS is to enable efficient work through passing down responsibility. This can be implemented right now with the same amount of staff and supports existing law and initiatives. Further on a Supervisory Board, which gives direction and a multi professional Management Board for managerial leadership of the NHS is essential. Board members need a lot of experience and general as well as change management skills. A general manager has the overall performance responsibility, but also a greater scope to adjust the management structure to local situations and requirements as it fits best and has to get reports from the functional management. For a faster decision making and implementation a reduction of involved staff members at all levels and in numbers is beneficial. (Griffiths, 1983)

2.2 Analysis of Hospital Management in Austria

The federal law (Bundesgesetz über Krankenanstalten und Kuranstalten, StF: BGBl. Nr. 1/1957 NR: GP VIII AB 164 S. 22. BR: S. 121 (KAKuG)) as the basic law and the implementation law (e.g. Gesetz über Krankenanstalten (Spitalgesetz), Vlbg LGBl.Nr. 54/2003 (SpG.); Tir KAG) in each Austrian state/province (Bundesland) regulates the hospitals in Austria. According to § 3 section 1 KAKuG the respectively state government has to authorize if a hospital is to be built or run in Austria. § 6a sections 1 and 2 KAKuG state that the federal state law can apply provisions on the medical, administrative and nursing directors of a hospital and that the rector of the medical university is an adviser to the three directors during meetings, if the hospital is also doing research and teaching. Each hospital needs a medical, administrative and nursing director, which are in charge of the respective range of duty as in §§ 7, 11, 11a sections 1 KAKuG and §§ 32, 37 sections 2 and § 40 section 1 SpG.. The three directors have the duty to inform and to consult each other (§ 29 section 3 SpG.). As laid down in § 40 section 1 and 3 SpG. the administrative director is not allowed to be in the same time the medical director and if decisions influence the medical service/operations consent with the latter one needs to be achieved.

3 MANAGEMENT IN HEALTH CARE

There are books written solely for management, leadership, and each topic of the following different headings. Therefore, this chapter provides only a small but comprehensive overview.

Management can be defined as a process to achieve organizational goals through actions, both technical and interpersonal by providing leadership, supervision and coordination of coworkers and the efficient use of resources. Additionally, it serves as an organizational control system and has to have rational goals, motives and means. Management is subdivided into an institutional and functional dimension. The former comprises the authority to issue orders and the power to direct tasks. This is done in a horizontal way through different departments for coordination and to meet effectively the institutional objectives. Performing actions and tasks that are needed to manage count among the functional management. (Robbins and Coulter, 2002; Reimer, 2005; Hammer and Kaltenbrunner, 2009; Burns, Shortell, and Kaluzny, 2011; Buchbinder and Shanks, 2012)

3.1 Managerial Functions

The managerial process comprises following functions that are management core competencies and used to make decisions. There are slight variations in the literature of the definition, but this principles of management are currently often condensed into planning, organizing, directing and controlling, as shown in figure 3.1 on page 8. (Longest, Rakich, and Darr, 2000; cited in: Buchbinder and Shanks, 2012; Robbins and Coulter, 2002; Bea et al., 2005; Hammer and Kaltenbrunner, 2009)

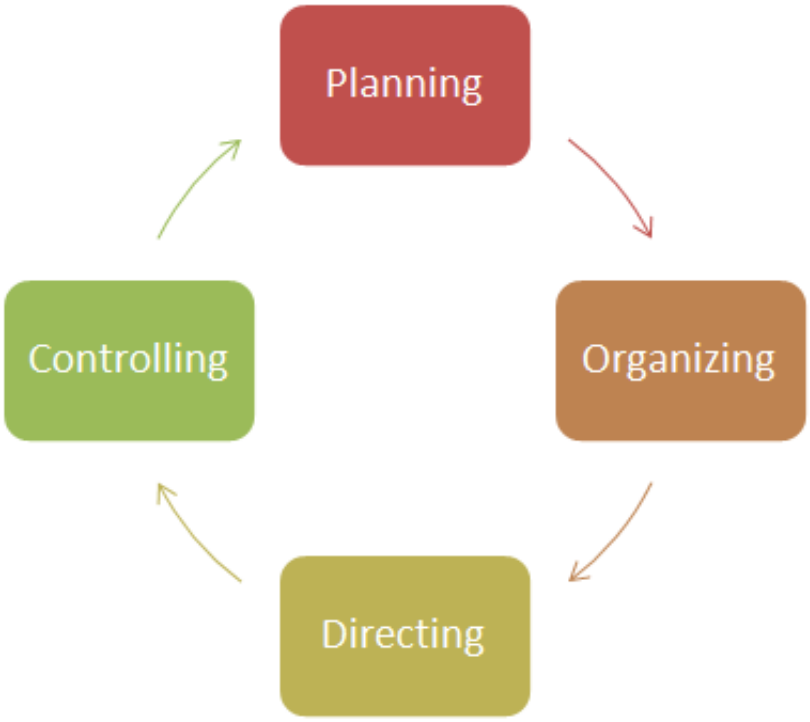

Figure 3.1: The four management functions. Source: Fulfilling the Organizing Function - Principles of Management

3.1.1 Planning

Planning is a rational process that sets direction, goals and performance indicators, looks at the environment, at alternative solutions to reach the objectives and the certainty to get there. It anticipates future strategies and actions to reach its targets while facing suspense and a lack of information and contributes to coordination and reduction of uncertainty, redundancy and waste. It's goal oriented, initiating change and adapting to it, but also trying to reduce the impact of shift. Plans are executed by people and used as standards, especially for controlling. However, the final actions may differ according to the current situation, due to the constantly changing process. Planning serves itself several tasks, e.g. leading and allocating, performing, optimizing, save guarding and coordinating. Its types are segmented into the level (normative,

strategic and operative), time dimension (short to long term), scope, area of activity, context, outside-in and inside-out (adapt to and influence environment, respectively), potential program and process planning. All other following functions are highly determined by this first step. (Longest, Rakich, and Darr, 2000; Robbins and Coulter, 2002; Bea et al., 2005; Reimer, 2005; Hammer and Kaltenbrunner, 2009)

Vision and Mission

The Vision and Mission statement defines and keeps a focus on the primary purpose and on the future where the institution wants to go and what to become, respectively. It is set by the owners and top management, has no time frame and is qualitative and value oriented, which in turn determines the organizational culture. (Hammer and Kaltenbrunner, 2009; Burns, Shortell, and Kaluzny, 2011; Buchbinder and Shanks, 2012)

Strategy

The strategy deals with proactive planning, defining goals, considering other key player in the company's setting, long-term acting and allocation of resources. It answers in which business area the institution operates, the way how it competes and collaborates and what the core competencies and the competitive advantages are. This leads to the development, execution and update of a strategic plan, using for example the SWOT or the Five Forces Model. During this process an analysis of internal and external information is done for assessing and adapting to possible future barriers and obstacles. The top management specifies the strategic business plan, which describes both qualitatively and quantitatively the overall objective for the whole institution. The long term perspective ranges from approximately three to seven years. (Longest, 1997; Robbins and Coulter, 2002; Reimer, 2005; Hammer and Kaltenbrunner, 2009; Burns, Shortell, and Kaluzny, 2011; Buchbinder and Shanks, 2012)

Operations (Goals & Objectives)

On the operative level the strategic targets get specified and implemented. Middle management works out clearly defined annually, monthly or even weekly functional plans and budgets. They focus on a shorter period, usually ranging from one to three years and define quantitative subgoals. (Robbins and Coulter, 2002; Reimer, 2005; Hammer and Kaltenbrunner, 2009)

3.1.2 Organizing

In this function plans get implemented through the creation of both formal process and workflow management, e.g. flow and bar charts and organizational structures by defining responsibilities, processes and procedures. Further on it includes the assignment of roles with the inherent authority and accountability and explicit rules. Those regulations contain for instance an organogram, job descriptions and business processes. The structures are divided into specialization, coordination, hierarchy levels, delegation of decision making and formalization. Organizing contributes to the continuity for achieving the company's objects and to the business preservation and development. Through a rise in productivity, flexibility, security as well as staff training and development the latter is reached. (Longest, Rakich, and Darr, 2000; Robbins and Coulter, 2002; Bea et al., 2005; Reimer, 2005; Hammer and Kaltenbrunner, 2009)

Organizational Design

The organizational and service design is a continuous process, where constant redesigning takes place. The business processes derive from the strategy and are adjusted if needed. Those are nowadays dominant and determine the structural characteristic of an organization. At last the management structure, which should be as flat as possible get changed accordingly to the defined processes. (Longest, 1997; Hammer and Kaltenbrunner, 2009)

3.1.3 Directing

Determining the goals and direction of an institution and coordinating and representing it is part of this managerial function. Directing includes effective and good leadership, information and communication, delegation and motivation, integration and participation as well as working with people. This important tasks are needed to improve the feasibility and to achieve organizational goals. (Longest, Rakich, and Darr, 2000; Robbins and Coulter, 2002; Bea et al., 2005; Hammer and Kaltenbrunner, 2009)

Staffing

The first step is to find appropriate staff for the defined roles and job descriptions as set in the organizing process (chapter 3.1.2, p. 10). The importance of HR management in hierarchical

organizations is acknowledged and increasing due to the attitude and mindset that the people are one of the most valuable resource of an institution. They are seen as an asset and therefore a big focus is laid on the employment, training and retaining of staff. (Longest, Rakich, and Darr, 2000; Robbins and Coulter, 2002; Reimer, 2005; Hammer and Kaltenbrunner, 2009)

Leadership

Leading oneself and others means developing skills, having managerial authority, setting business defined and common goals and to engage and influence employees to achieve these. One of the difference between a leader and manager can be described that former focuses more on the external communication with stakeholder and gives the direction, while latter has a greater internal view. Since the 1920's different leadership models emerged and got refined, currently applying the adaptive one, where flexibility is needed. (Longest, 1997; Robbins and Coulter, 2002; Burns, Shortell, and Kaluzny, 2011; Buchbinder and Shanks, 2012)

The well-known studies from the Universities of Iowa and of Michigan identified an authoritarian, democratic and laissez-faire **leadership style**. Those initiate both structure, being production-centered (definition of tasks, roles and focus on productivity) and staff consideration, correlating as employee-centered (focus on interpersonal relationship during work processes). When the supervisor defines the goals and duties alone, he uses the authoritarian or coercive style. In the participative or democratic one the subordinates take part in the decision making process, therefore increasing the identification with the task. The integrative or coaching approach comprises that the superior only provides technical and counseling support. The loosest is the laissez-faire or delegating style in which the superior exerts only supervision. The used leadership styles are not mutually exclusive, but form a fluent passage from one to the next, depending on the urgency of the situation or problem as well as on the education and motivation of employees. (Robbins and Coulter, 2002; Bea et al., 2005; Reimer, 2005; Hammer and Kaltenbrunner, 2009; Buchbinder and Shanks, 2012)

The following **management techniques** are used for leadership and aim at either delegation or target principles and differ accordingly. Former contains management by-exception (intervention only in exceptional cases), by-delegation and by-decision rules (delegation and given

rules). Management by-results (predefined goals both set and controlled from management alone, the way to achieve them is not important) and by-objectives (manager and employee set goals and doing the review of the results together) belong to the latter category. The Harzburger model assigns the field of duty with its competences and delegates responsibility. The decision making happens on the hierarchy level where they become operational, thus building the organization bottom-up. (Robbins and Coulter, 2002; Bea et al., 2005; Reimer, 2005; Hammer and Kaltenbrunner, 2009)

Decision Making

To create the highest value by effectively solving a problem the decision making process is used to look for solutions. It identifies a problem and the decision criteria, allocates weights to them, develops alternatives, takes into account all their risks and benefits and at the end the best one is chosen and implemented (Longest, Rakich, and Darr, 2000; Robbins and Coulter, 2002), whereby different models can be used. Decisions can be differentiated into programmed and non-programmed calls. They belong to former when they are iterating, easy to take and routine, selecting effective processes and are written down as standard operating procedures (SOPs), which are based on past results. The non-programmed decisions are innovative, creative and unstructured, selecting effective solutions for adaption. Management can't draw on SOPs because they are not yet established due to the unpredictable but specific problems. More information and cooperation is needed to solve the problems at hand. To improve decision making and its implementation the employees should be involved during this process (Saltman, Durán, and Dubois, 2011) and make use of techniques like the devil's advocate. In this approach an appointed team member challenges deliberately new ideas, assumptions or proposals and brings up dissent to engage communication and learning. Another one is the dialectical inquiry, where each of various teams generate alternatives and then present the best one. The management and the groups together pick the best parts form all proposals and by this bring up a new and best solution. (Jones, 2010)

Communication

Communication is the transfer and understanding of meaning from a source to a receiver (Robbins and Coulter, 2002). A good and open communication contributes not only to better patient

care but also to higher staff satisfaction and employee retention and is crucial to provide constructive feedback (Buchbinder and Shanks, 2012).

Unit/Groups/Teams

Teams can increase the effectiveness of and commitment to an institution as well as moral and job satisfaction. For an efficient delivery of care, the complex work in hospital makes team building inevitable. Groups and teams are build, managed and controlled to achieve targets especially at the operational business level. Therefore, work tasks and roles are assigned and the performance monitored. The five stages each team goes through are forming, storming, norming, performing and adjourning. When putting up a team it is important to think of various points, e.g. it's members, goals, meetings, indicators, to whom someone is accountable, the given role and responsibility. Burns, Shortell, and Kaluzny stresses that both informal and formal groups can possess substantial power in an organization. Nevertheless, they increase synergies, productivity and the empowerment of employees. Yet, the strong suite of teams lies in combining the diverse expertise of the team members, contributing to a multidisciplinary knowledge. (Burns, Shortell, and Kaluzny, 2011; Buchbinder and Shanks, 2012)

Motivation

Employee motivation plays an important part to achieve personal and organizational goals. Motivation theories range from needs based to extrinsic or intrinsic factors, although the latter is to favor (Buchbinder and Shanks, 2012). Motivation also tries to increase both the job and psychological maturity of the staff, including technical knowledge, self confidence and trust in oneself. According to the level of maturity Reimer (2005) states that the one or other leadership style is more appropriate to use, as mentioned in chapter 3.1.3, p. 11. The added value can manifest in higher maturity, greater latitude for top manager to focus on management functions and improved employee motivation and identification with business goals (Hammer and Kaltenbrunner, 2009).

3.1.4 Controlling

At the end of the management process is the scrutiny for target-performance comparison. It includes the assessment and analysis of deviations, their reasons and the forwarding of all the information to the management. These tasks build the foundation for both the operational and strategically controlling, which are operative plans and budgets and the environment pertinent to the business, respectively. The scrutiny function becomes controlling only after the extension with the amendment, control and steering functions. Controlling includes all tasks for information supply for the management and for targeted coordination of decisions through implementation of concepts. It monitors actions and outcome, evaluates if work and performance goes as planned and applies interventions if needed. The use of managerial tools like strategic planning, budgeting, project, performance and HR management, marketing, quality affirmation and contracting maintains control of organizations (Flynn, 2007). Organizational authority with its rules, regulations and processes build the bureaucratic type of control. The next is the clan control, which is defined through shared values, believes, norms and traditions of the organizational culture. For the prevention of possible future problems the feed-forward control is used to take action before a problem arises. The current control is executed through direct supervision during a process. The last type is the feedback control. It provides information if plans were good after accomplishment of the task and can improve staff motivation. (Longest, Rakich, and Darr, 2000; Robbins and Coulter, 2002; Bea et al., 2005; Reimer, 2005; Hammer and Kaltenbrunner, 2009)

3.2 Managerial Skills

Management skills are behavioral, sometimes contradicting, interrelated and overlapping and can be controlled and developed, but this takes it's time. They involve interaction with people and are not as straight forward to apply as other skills (Whetten and Cameron, 2011). It is essential to develop, adapt, constantly work on and improve each skills, because they are key to successfully execute the different management functions (Robbins and Coulter, 2002). These competencies are divided into conceptual, technical and interpersonal skills. Depending on the hierarchical level and accountability the one or the other will be more important (Katz, 1974).

To this three skills Burns, Shortell, and Kaluzny (2011) identified a fourth one. It is important to have knowledge of the industry the manager is working in. For instance, important laws and regulations, the reimbursement system and all major stakeholders that might affect the health care system should be known.

3.2.1 Technical Skill

The use of expertise and specialized knowledge are known as a technical skills. Designed, performed and implemented tasks, which are involved in processes and methods contribute to this skill too. This one is most important on the lower levels, where the business operations happen and where core disciplines are applied and dealt with, like HR management and accounting. (Katz, 1974; Burns, Shortell, and Kaluzny, 2011; Whetten and Cameron, 2011)

3.2.2 Human Skill

This competency contains both communicating and establishing, maintaining and enlarging constructive cooperation of people within teams and between groups. This happens at any organizational level through clear and persuasive communication. Although, the leadership style will differ when working with the own unit or cooperation between groups has to be facilitated. Latter is more important and common at higher levels. Human interactions are needed at every hierarchy level and can pay off for own technical deficits. Therefore, building trust and respect is essential for the delegation of tasks to and engaging of subordinates with a good technical background. (Katz, 1974; Burns, Shortell, and Kaluzny, 2011; Whetten and Cameron, 2011)

3.2.3 Conceptual Skill

Distinctive conceptual skills are most essential for the top management, because a critically analysis of complex problems is a premise to come up with strategies and models. By defining the problem, developing and evaluating alternative solutions as well as choosing and implementing one these issues can be solved. They have to see the whole system and how changes in parts of it will affect the rest. To fulfill the organizational objectives information transfer and knowledge usage to analyze situations and to obtain coordination is crucial for management.

Katz emphasizes to judge on performance and not on traits and to improve the conceptual abilities through practice. The help of supervisors or mentors and self-reflection can be a way for development. (Katz, 1974; Burns, Shortell, and Kaluzny, 2011; Whetten and Cameron, 2011)

3.3 Conflict and Crisis Management

Goals of different groups and their perceptions and ideas how to achieve them interfere and compromise with each other, leading to organizational conflicts. As far as effectiveness and learning is increasing, conflicts do not have to be perceived as bad. When the level is not too high and handled properly they ensure innovation and improvements, hence are beneficial for organizations. (Jones, 2010; Whetten and Cameron, 2011)

The two types of conflict are based on its focus (what's this about?) and source (how did it started?). Former includes issues, dealing with competition of ideas, proposals and resources or people, which is harder to solve. The reason for this is that it has to take into account what happened earlier between parties. Sources of conflicts can be personal differences (perceptions and expectations), informational deficiencies (misinformation and misinterpretation - common but easy to fix), role incompatibility (conflicting roles and responsibilities), environmental stress (scarce resources and uncertainty) and different perspectives or sources of power. (Burns, Shortell, and Kaluzny, 2011; Whetten and Cameron, 2011)

Stage one of Pondy's model of organizational conflict is the **latent conflict**. The interdependence and different goals of units, bureaucratic behavior, contradictory goals and targets and the battle for scarce resources are potential for a dispute to arise. The **perceived conflict** is the second stage where the own goals are perceived to be threatened by other departments. Both parties begin to analyze the underlying cause and what led to the arising conflict. Emotions, polarization and a decline of cooperation and institutional effectiveness are characteristics of the **felt conflict**. If not resolved the strife will reach the next level, adding open and mostly passive aggression. The **manifestation** of the **conflict** includes additionally 'doing nothing' to compromise others goals, grinding cooperation, communication and integration to a halt. Further work and interactions of both parties in the **conflict aftermath** depends how the earlier

clash was solved. It may arise again if the source of it was not addressed. (Jones, 2010)

Common mistakes when engaging in conflicts are fail to plan and to think through (focus on interests and needs), to calculate too less time for talking and choosing an uncomfortable surrounding. This often results in functional fixedness, confirming evidence bias, or the inability to use information to solve new situations. (Burns, Shortell, and Kaluzny, 2011)

Jones describes that both changing the structure of the organization, influencing the attitudes of people and replacing them can resolve the root of a conflict. Former is working on a better integration of different units using incorporating mechanism like task forces, teams and liaison roles. The design of the hierarchy, accountability and resource distribution has to match the organizational needs. In the latter (stage of felt conflict) the view points of the others are heard and mediated between them. Besides, direct negotiation, rotations of staff between units to enhance learning and understanding one's specific issues, or removing people form current position can foster to solve issues. The top management with its CEO has major power and influence to manage discords, consequently to show commitment in solving these. (Jones, 2010)

The five approaches for conflict management defined by Whetten and Cameron, which a superior or mediator can choose of vary depending on the trade-off to satisfy the concerns of both parties. **Forcing** contains the use of authority, threats and manipulation assert the wishes of one party on the expense of the other. The inverse of the former, **accommodating** tries to please the other party and neglect the own concerns. When **avoiding** and not taking care of the conflict both groups get neglected. Both parties to the dispute have to make sacrifices when the **compromising** approach is chosen. **Collaborating** tries to solve the conflict on its roots, focuses on issues, openness, directness and equality and is therefore the best and preferred of all alternatives. Tactics to succeed are threefold and address to do research, ask questions and find a common ground to i) get more information. Moreover, ii) finding a better solution by adding issues, providing nonspecific compensation, fractioning or packaging offers and iii) influencing the other party through a good opening offer, objectivity and coalition building contributes to the management of conflicts. (Burns, Shortell, and Kaluzny, 2011; Whetten and Cameron, 2011)

3.4 Negotiation

Negotiations between different social worlds sharing the same territory are challenged and refined from the involved parties, which can lead to conflicts. Yet, formal and informal negotiation is an appropriate tool to solve disputes. Therefore, the manager as a negotiator needs a double vision or multiple social identities to succeed. (Star and Griesemer, 1989; Bowker and Star, 1999; Burns, Shortell, and Kaluzny, 2011)

As in any social organization negotiations are necessary, particularly in health care institutions, where they are apparent. Bargaining takes place in interpersonal relationships through specific structural properties. Its strategies are divided into the preferred integrative (expand the pie by collaboration) and distributive perspective (distribute 'fixed pie') (Whetten and Cameron, 2011). Important to note is that negotiations take place on two levels and can be described as 'around and about rules'. Characteristics of informal interactions at the work place concern the former, while the latter deals with the need to implement policies and institutionalize. In hospitals for instance, it is the dominance of the professions which inhibits the influence of the nonprofessionals to change working processes in the medical setting. Preconditions to achieve cooperative structures are making concessions and relinquishments, to enter useful relationships and to stop re-bargaining of already agreed points. The process of negotiation can be divided into tasks that involves bargaining from the extreme sides of the spectrum to reach compromises in between, reaching tradeoffs, explore acceptable boundaries, demand of territory and ongoing contracting. By educating, manipulating situations and using persuasion alternatives can be chosen compared to negotiation. Preparation and arrangements are useful when dealing with the party with the smallest benefit or highest loss during the negotiation process, due most resistance will come from those. (Regan, 1984)

4 MEDICAL VS. NON-MEDICAL BACKGROUND

A lot of literature tries to answer the question of who should manage and lead a hospital: is it the general or the professional manager? The following paragraph will explain why managing hospitals is a very special and complex task and why there is a lot of controversy and no clear and straight answer to this question.

Professional bureaucracy refers to the standardization of skills of highly trained specialists working at the operating core of organizations, e.g. treating patients in hospitals. The professionals can focus on improving their skills, because of the specialized knowledge there is no great need of coordination with others. In addition, the complexity and specialization ensure a high professional autonomy and independence. Therefore supervision and control is hardly executable but by their peers. Stoopendaal (2009) points out that the variety of medical work, professions and fragmented organizations contribute to this situation. This is the reason for the two hierarchies in hospitals, the bottom-up (power of expertise) and the top-down (hierarchical power). Fragmentation and specialization led to the four differentiated yet important worlds in hospitals and health care: cure, care, control and community (see figure 4.1, p. 20). Due to the corresponding different mindsets, the system is not manageable and incomprehensible, as Glouberman and Mintzberg stresses. Finally, the ongoing battle of power is based on the clash of the professional work with the managerial logic. The world with the most power is related to the class of capital, which weights most. These are the economic, social and cultural capital and involves money, connections and background, education and social status, respectively. (Mintzberg, 1983; Glouberman and Mintzberg, 1998; Witman et al., 2011)

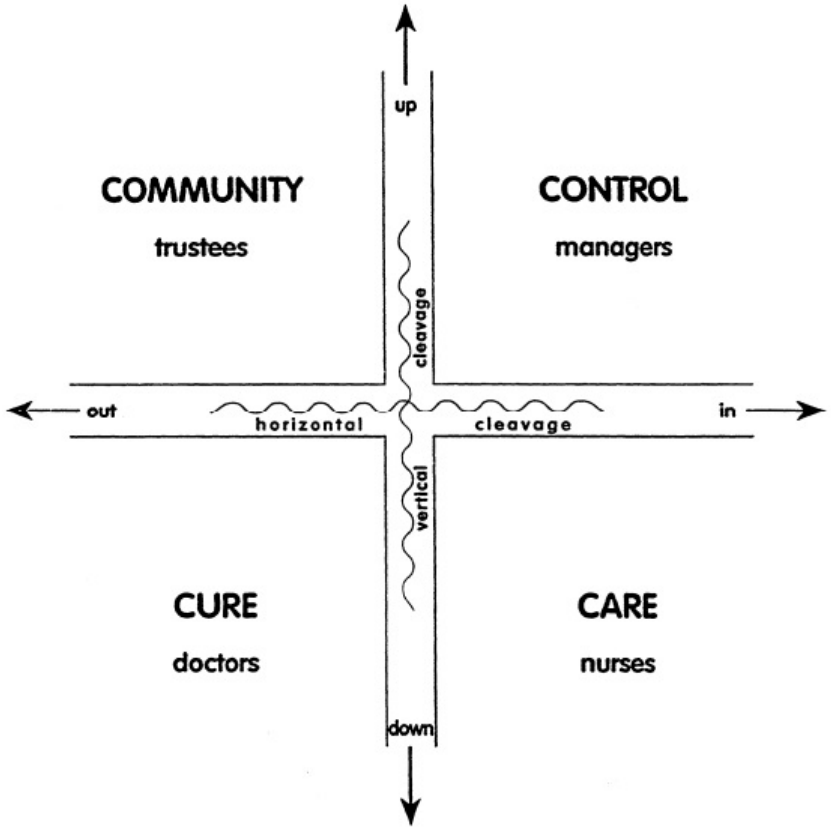

Figure 4.1: The four worlds of a hospital: Cure, Care, Control and Community. Source: Glouberman and Mintzberg (1998)

4.1 Analysis of the General Manager in Hospitals

Mintzberg and Glouberman see the roles of a hospital manager to promote self-management within the clinical setting. It is achieved by strengthening both the culture in the hospital as well as the adaption and coordination of working processes through informal communication. Latter is known as mutual adjustment. His scope also comprises to handle problems and arguments between specializations and departments in the organization and to provide the link between parties in and outside of the hospital. The manager is not involved in clinical operations but has control over the institution. According to figure 4.1, he manages up to deal with decisions affecting the hospital (control and funding of the organization), but also inwards to engage all different professions to work together for decision-making. Thereby using a tech-

nical and rational approach. This means his focus is on the overall institutional needs and the whole population of patients. In contrast, the physicians are concerned with the single patients and feel only accountable to them. This connotes to manage down and out, being involved but independent. (Mintzberg, 1983; Mintzberg and Glouberman, 1998; Edmonstone, 2009; Witman et al., 2011)

Health executives have to find a trade-off between control from the distance of practice versus bridge and culture building. This equilibrium of physical, temporal, emotional and social distance and the right involvement is important, otherwise it will be perceived as either a lack of interest or interference into work. The distance can be managed through extensions (bringing together the quadrants), connections (boundary object known by both worlds), meeting places (informal communication) and boundaries. Limited resources and amount of time spent on the floor are the main causes for (felt) distance. Yet, if a manager walk the talk of the organizational values, he can become an interested and binding outsider. (Mintzberg and Glouberman, 1998; Stoopendaal, 2009)

His source of power lies in the economic, social and cultural capital. In other words the general manager is in charge of the money and its distribution, has easy and fast access to the board and economic knowledge, respectively (Witman et al., 2011).

4.2 Analysis of the Professional Manager in Hospitals

The definition of clinical leadership can vary depending on the view of the literature. It is used as a tool to achieve managerial goals, but can be seen from the management perspective as elitist and without litigation. Malby (1998) and Noordegraaf (2007) state that clinical leadership is given when staff with medical background takes the position of a leader, when he is both physician and manager. (Edmonstone, 2009; Spehar, Frich, and Kjekshus, 2012)

A few differences between clinical and more generic leadership were already mentioned in section 4.1, p. 20. Besides them, the professional manager can be the ideal linkage between the two worlds, where he moves along group boundaries. This comes because it is harder to learn

medical knowledge and thinking for managers (except language and processes) than vice versa. In the physician's world, two important and unique characteristics have to be kept in mind. First, authority is gained through group membership, seniority and experience, which implies no line authority. Secondly, the rules of collegial manners state to use shared and evidence based decision-making and not to give orders or control others. (Witman et al., 2011)

A physician has to face and deal with special issues when taking a managerial position. Although clinicians have skills, knowledge and influence, many are unprepared when they get into leading roles, are too focused through their specialization and are lacking of leadership. This is apparent from a huge workload, insufficient delegation and not well enough known terminology related to finance, health, safety and environment. In addition, communication and teamwork are hardly found in the curriculum (Buchbinder and Shanks, 2012) during their very long training and education, yet especially these two skills are so crucial. These problems get amplified even more when the managerial job is taken out of extrinsic motivation. Reasons to do so are manifold. It can be the protection of the profession from competing influence, pressure and supervision. Other grounds are to keep their autonomy and control over work. However, the hardest task for a physician in a leading position is to deal with matters within but also outside of the organization as he has to steer, manage and support his peers while not conflicting with the collegial manners. Since professionals are controlled through content by themselves (Noordegraaf, 2007), for example during discussions, the professional manager can quickly loose authority. By devoting part of his time to management tasks or balancing between individual patients and the complete patient group he becomes one of *them*. (Mintzberg, 1983; Mintzberg and Glouberman, 1998; Edmonstone, 2009; Witman et al., 2011; Spehar, Frich, and Kjekshus, 2012)

Therefore, the leading physician has to find a good trade off point between time working in his profession and influencing decision making to manage his peers and keep the support of them. He can influence his coworkers by authority through expertise, by respecting the collegial manners using manipulation, power to convince and persuasion and by pressure through the group to bypass a direct order. The next and last two actions, which he can take contradict to their rules. Using explicit pressure and process intervention within the group will stir up arguments

and confrontations but are needed to protect the whole group. A professional manager will develop a strong leadership and steering mechanism and be in charge of the group by knowing when and which of this five approaches to use. Likewise, he should be able to work with some management tools, adapt and modify them accordingly to the medical world. Swanwick and McKimm (2011) and Spehar, Frich, and Kjekshus (2012) point out the importance to adjust the curricula and define a career structure that match today's need regarding soft skills. Some frameworks have been developed or are under way and should support medical staff to enter management positions. (Mintzberg, 1983; Edmonstone, 2009; Witman et al., 2011)

The professional manager draws his power from cultural capital (personal influence, medical knowledge and reputation), social capital (power of the whole medical group) and economic capital (generation of money through research or treatment). In the interest of all parties, a careful consideration of whom to choose as a professional manager is beneficial. Especially the motives have to be questioned if there is just no one else doing the job or if a higher interest in management is existent. (Flynn, 2007; Saltman, Durán, and Dubois, 2011; Witman et al., 2011)

Little attention is paid to nurses who are doing management on the front line. They are coordinating all sorts of procedures of coworkers from different specializations. Despite that, nurses have seldom authority over this people, it is questionable that doctors would accept a nurse in leading position (Mintzberg and Glouberman, 1998), although that they and the general manager lead a far greater number than physicians do (Witman et al., 2011).

4.3 Importance or Negligibility of the Manager's Background

The bigger the specializations and differences in the hospital and respectively health care sector get all the more integration is needed between them. Like patients, these organizations and systems need steady and cooperative care across all quadrants. Therefore, managers need to engage all four blocks into a system wide and throughout collaboration, especially by looking across the horizontal cleavage to reduce competition (see figure 4.1, p. 20). (Glouberman and Mintzberg, 1998) Nevertheless, what are the preconditions to collaborate and drive integration forward?

To manage the various tensions and opinions between people belonging to different social worlds a continuing and steady relationship between them is needed. Being a professional means having and maintaining boundaries for keeping others out, although hospitals work best when relations and networks among different specializations are established. This implies a shift of boundaries and power. Therefore, a better balance and stronger coordination between worlds is needed, with a focus on architectural reorganization. (Mintzberg and Glouberman, 1998; Bowker and Star, 1999; Noordegraaf, 2007)

Managers have to deal and act accordingly with the many boundary conditions in the hospital (four worlds), using different skills when working together with people in the one or the other quadrant. The situations for a manager will be very different to handle when he is reporting to the board, negotiating with politicians, working on employee retention or bargaining with the professional staff. (Mintzberg, 1983; Mintzberg and Glouberman, 1998; Buchbinder and Shanks, 2012)

There is a need for mutual adjustment, communication through informal meetings and arrangements to get one common culture and the same beliefs. The representation of the information on intersecting points between the worlds is important, because the different views not only need the forwarding of the content but mainly its translation. For fruitful cooperation's the understanding to overcome management and professional discrepancies but also being aware of some (everlasting) remaining differences is absolute. By gaining interdisciplinary knowledge, meaning knowledge acquisition of the other field of expertise, the manager lays the foundation of becoming a boundary object. (Star and Griesemer, 1989; Mintzberg and Glouberman, 1998; Noordegraaf, 2007; Stoopendaal, 2009; Witman et al., 2011)

Star and Griesemer (1989, p. 393) define boundary objects as *"those ... which both inhabit several intersecting social worlds ... and satisfy the informational requirements of each of them. Boundary objects are objects which are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They are weakly structured in common use, and become strongly structured in*

individual-site use. These objects may be abstract or concrete. They have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable, a means of translation. The creation and management of boundary objects is a key process in developing and maintaining coherence across intersecting social worlds."

It has to be stressed that boundary objects are not build. They develop during work but only if a relationship exists. In addition, they have to be seen as shared objects across communities. When satisfying all their demands a common boundary is created and the objects manifest in different sectors concurrent. The same objectives of an organization have to be followed by all worlds and still problems can and will arise at the boundaries of the different quadrants through tensions. The autonomy of the manager is based on solving these (Mintzberg, 1983). Persons who act as such an object need flexibility, double vision and more identities to negotiate. Therefore, they have to align the varying languages and meanings to manage mismatches between the different groups, being an agent of communication. Making the transition from boundary objects to become the approved standard within and across the divergent communities is the final goal to achieve. (Star and Griesemer, 1989; Mintzberg and Glouberman, 1998; Bowker and Star, 1999)

However, it is no easy task to be part, moreover to be a member of multiple worlds. These marginal or boundary people face a lot of stress because of the various roles and identities, which he or she has to simulate. Those persons manage this situation either by passing by, commuting between, trying to fit into only one social community or founding a new one. (Star and Griesemer, 1989; Witman et al., 2011)

Due to the adaption of social changes, traditional professional groups get weaker and vocational ones are professionalized. This trend led to hybrid professionalism, giving rise to managerial professionals and professional managers. They have to set control in context of connections between organizational groups, their actions and working processes. The issue is not *that* but *how* and of *whom* professionals are controlled (see section 4.2, p. 21). Managerial tools conflict with their working habits, but through (de)professionalizing the complex settings can be controlled. The content of control matters. (Noordegraaf, 2007)

In a panel discussion various experts from academics (Federeco Lega, Hans Maarse, Jari Vuori), medical professions and health management (Antonio Durán, Jeni Bremner, Armin Fidler) and health care management and policy (Marianne Olsson, Andreas Steiner) had very different opinions if a medical background is needed or supreme when entering management positions. Summing up some of their remarks, managing health care organizations is very complex and not comparable to any other company. The greatest discrepancies between these experts regard the background of the manager and ranges from one side of the spectrum to the other. Some argue that the medical education is no prerequisite to lead hospitals. Others say that it may be beneficial but not efficient to train medicine for such a long time and then enter management. Yet, a group thinks that a clinical background is a valuable investment. Nonetheless, most are confident that education and training is crucial to understand the given complexity. Like Mintzberg and Glouberman they emphasized that the question who should manage a hospital might be the wrong one. The focus should rather be on the skills, values and functions of interdisciplinary working people and the structures of the institution. It is essential not to think in categories, but that we look for motivated and skilled leaders who can bring the four worlds closer together, so that cooperation and collaboration can be (better) done. A specialist representing a single one might be outdated. (Mintzberg and Glouberman, 1998; Walch, Petter, and Saes, 2010)

5 PUBLIC-PRIVATE PARTNERSHIP

Flynn (2007) describes different forms how to manage the public sector, which range from audits and inspections to collaborations, the use of markets or contracts, or to privatization and public-private partnerships (PPPs). In this chapter, the focus will be on the nature of PPPs.

5.1 Definition of PPP

A PPP is a collaboration between the public and private sector, resulting in a long-term contract. In the setting of health care, the government collaborates with a company or consortium of various companies. Those are specialized in architecture, construction and refurbishment, financing and provision of other services (e.g. management, catering and maintenance). There are different models of PPPs, though the financing is brought in most of the time by the private part. Regular fees during the contract time are paid by the government to cover this costs and services. E.g., most of the since 1997 newly build or extended hospitals in the UK were financed through PPPs. In Canada the first hospital PPP was in 2001, now they are working on 26 hospitals projects alone in Ontario and some in British Columbia. (McKee, Edwards, and Atun, 2006; Flynn, 2007; Silversides, 2008a; Silversides, 2008b)

5.2 Reasons for PPP

One reason opting for a PPP is that the private company/consortium comes up with the money to build and operate an asset and/or provide the services. Consequently, the state does not have to borrow money to finance the acquirement. As mentioned in the introduction (section 1.1, p. 1) the financial crisis in 2008 put even heavier pressure on the state budget than already has been. Renewal of public infrastructure, hospitals included, are needed and PPP are a way to

get these built sooner or at all. The known market failures in health care retained this sector from privatization, though higher innovation and value for money wants to be achieved through PPPs. Further on the private sector is more efficient and reactive than the public one. Another cause is that all the various and simultaneous hospital projects will not be manageable by the government on its own. (McKee, Edwards, and Atun, 2006; Flynn, 2007; Silversides, 2008a; Silversides, 2008b)

To sum up, the reasons for entering into a PPP are sound when the possibility is given to spend the huge and one-time (would be) investment in different sectors or on other projects. In addition the gained advantage and profit from the expertise (e.g. project management) of the private partner is not to be undervalued.

5.3 Pros and Cons of PPP

There are several following **advantages**, which results from a PPP. The experience and expertise of the private sector can be used and leads to less surprises by knowing the costs more accurately through upfront planning. It can as well be used as a source of innovation and to get access to otherwise unavailable skills. Operations and service can be improved by higher provider flexibility, leading to a better adaptability to new situations. Problem sharing and shifting the risks to the private side brings benefits for the government. This also pays off the higher costs as would occur by usual procurement (see disadvantages: financing and transactions costs). Criticism oppose this argument by stating that the calculation of this payoff is inaccurate or more specifically, overrated and that health is fundamental and indispensable as a public good. Therefore, every government would take over and safeguard this sector in case of failures. In the year of the major purchase, there is no expense and therefore no money needs to be borrowed by the state, but since the allowance for depreciation, the bookkeeping advantage is gone. Anyhow, reallocation of resources to and focusing on core processes get enhanced. Because spending comes from private companies, an incentive is created for them to do their job quickly and well and additionally penalties should hamper poor performance. By selling the contract to a 3rd party (known as refinancing) profit can be generated and shared. Yet, it is important to put this term into the contract and to bear in mind that it can also incur higher pub-

lic costs under special circumstances. Budget and time targets of the projects are far better met than by conventional procurement, although a close eye has to be kept on quality, which may suffer otherwise. At last, outsourcing of old systems, services and processes do not need investments for their modernization by gaining outside technology. (McKee, Edwards, and Atun, 2006; Flynn, 2007; Silversides, 2008a; Silversides, 2008b; Heizer and Render, 2011)

Some of the more general **disadvantages** to bear in mind are the potential of higher transportation costs due to physical distance and the loss of control over, for instance costs and suppliers. Further on outsourcing can create a strong competitor (e.g. Intel and AMD) and may lead to a decrease of moral, motivation, trust and productivity of employees, particularly when jobs are cut back. Other cons, especially related to health care is the hazard that money needed for care is taken out of the health system, which happened in UK. The higher financing and transactions cost are a result of i) the higher interest rates of loans for the private sector compared to the state, ii) the returns to share holder that companies have to pay and iii) of the complicated and complex contracts (e.g. many companies, changes include penalties). Therefore, the government is confronted with low financial benefits and less public control. Transparency issues arise due to keeping business case and contracts confidential, even after awarding the contract. Conflicts of interest can come forth between the hospital board and consortium, when it comes to pursuing both risk minimization of the latter or further privatization. On the one hand having long term contrasts can be disadvantageous in itself. On the other, terminating them, replacing, or changing services respectively induce higher charges because of penalties. Costs of a lost bidding have to be compensated in following contracts, which includes higher quotations. It is very difficult to react fast to (major) changes in health care and the design of buildings may not beneficial for the users. Elaborate and tricky contracts add to the already complex health care setting. Due to this complexity enough time and brainpower has to be spend to get good, specific and detailed contracts (e.g. no contradicting incentives, based on outcomes). For this agreements knowledge is needed on both sides, but sometimes this is lacking from the public sector. Finally, a few of the negative impacts, as opposed to the advantages, may occur initially in the distant future. (McKee, Edwards, and Atun, 2006; Flynn, 2007; Silversides, 2008a; Silversides, 2008b; Heizer and Render, 2011)

6 EMPIRICAL DATA

The setting of the study takes place in Austria in the province of Vorarlberg. Focus will be on the state hospital Feldkirch, which is the biggest of the five hospitals in Vorarlberg. The hospital has 24 medical departments, a pharmacy, medical physics and a nursing school. It has approx. 600 beds and 2000 employees. (*Landeskrankenhaus KHBG - Portal*)

Documents, e.g. annual reports, presentation (*Landeskrankenhaus KHBG - Portal*; Nikolic and Maikisch, 2006) and information from the homepage of the hospital Feldkirch were used for the preparation of the interview and the confirmation of the results from the expert interview.

The interview took place at the state hospital Feldkirch with its administrative director Dipl. KH-BW Harald Maikisch, MSc. and lasted for approx. 70 min. It was conducted in German and translated afterwards by the author.

6.1 Elite Interview

Before taking on a job 1982 in the health care sector, he was working in the private sector with focus on sales and IT (implementation of a new system). His vacancy at the KHBG was focusing on organization, coordination and revision. The first task was the implementation of the IT system in the state hospital. He worked on manpower requirement analyses, contract design, make-or-buy analyses, financing and public procurement law and he built up the departments revision and controlling. From the beginning, he was working on outsourcing projects, e.g. the laundry, the cleaning, the kitchen or the technique. The state hospital Gaisbühel was dissolved and organizational integrated as a department in the hospital of Feldkirch. In other hospitals, the status quo of their organization was carried out. These processes were examined all the time and

depending on the economy and on offerings, in-sourcing was done too. He was the procurator and from 1991 until 2007, the deputy CEO of the KHBG and in charge of all big projects (e.g. implementation of SAP and the Euro). Since beginning of 2008, he is the administrative director of the state hospital Feldkirch.

6.1.1 PPP

It is important to see the outsourcing of the sterilization within a time frame and how you can implement things in a given period. An external company planned and took the centralized sterilization in Feldkirch into operations and then the hospital operated it. After 10 years the sterilization was too small and needed renovation within the given the structures. The external organization was done well but it was not sustainable enough. In 2003, the hospitals Hohenems and Bludenz faced the same situation. Out of it, the thought was developed to centralize and realize the sterilization as a PPP, because a specialist was needed. PPP was the new tool or solution for this problem, since the partner takes on responsibility too. The processes in the hospital are organized well, but to be profitable a minimum amount of 125.000 instruments (Sterileinheiten) is needed. Yet, even the hospital of Feldkirch as the biggest one was not able to reach this number on its own. Improvements were possible, especially concerning over-sterilization (Übersterilisation). During a surgery not all instruments, which are lying in a filter, are used. Nonetheless, these unused instruments are cleaned too and get haywire. This lead to the first task of a filter reorganizing and was done by an external company in cooperation with the nurses working in the surgical theater.

The results of the filter reorganization and standardization with the company SteriLog and the hospitals Bregenz and Feldkirch were outstanding. An expert partner with knowledge should be found in a tendering procedure and take on some of the liability. In the beginning, it was not clear how to set up the tender. Finally, it was done as a competitive, non-discriminating 3-step European wide procedure. An external lawyer was consulted for the design of this extremely complicated tender process. One of the last three bidders was chosen as partner, who contributes resources, e.g. money, a building pot or knowledge. The expertise was the needed resource for this project.

As deputy CEO of the KHBG he informed the supervisory board during the project and they approved all steps and decisions. Since some board members are politicians (state government member for Health and Infrastructure), the communication into politics was given through the board of directors. Since this project did not concern the public, no communication was directed towards them. The top management of the hospital was an important partner and the employees were the most crucial stakeholders and therefore well informed. He knew that he has to convince the physicians for a positive project outcome. At the start, he worked intensively with the surgeons. Astonished he found out after some discussions that they do not care where the instruments are cleaned, as long as they are of good quality. Far more important were the nurses working in the theaters with the filters (regarding the weight and the preparation). Therefore, he involved them as the main stakeholders. A change of the plan (time line, resources, milestones, activities and meetings) and flexibility was necessary. It is crucial to select and work with employees who support your project, who are motivated, fast learners and effective. Working processes were known from the time when the manpower requirement analysis was done. The Medizinprodukteaufbereitung Vorarlberg GmbH (MPAV) was lead for one year by Harald Maikisch. Another point why he worked very close with the nurses was to motivate them to work in the newfound company. During planning, it is important to think of possible implications and the stakeholders, which can get complex and hence requires flexibility.

The three possibilities were doing it by your own, contracting out or the middle ground as PPP. The first alternative was done until then. Contracting out would have been extremely difficult, since there was no provider offering this service and no one would have invested so much for a 5 year tendering. Additionally, service level agreements would have been needed and the hospital would have not been involved in the management and steering. A PPP with a common company and an accountable partner was the right solution at that time.

The most important factors during the preparation phase are the project design, change management (main reason for failure of projects), communication with stakeholder, the law regarding the complex tendering process, profitability (business plan and break-even) and the building project with the logistics. After one year, the CEO was passed on to the person who accompanied Harald Maikisch during this year.

Two things that worked out very well are the confirmation of an external consultant and the financing. The governor of Vorarlberg engaged intensively the outsourcing and scrutinized if it will work. Since all was planned and done in-house, except the tendering, an external consultant checked the whole project and confirmed the project plan. Harald Maikisch saw this as an opportunity to prevent flaws and since none were found the project was implemented with even a bigger assurance. The MPAV started operating in 2007 and they are still align with the business plan.

The main concept provided for relieve of the hospital budget since the partner should invest knowledge and money for this project. At this time was a period of low interest rate and the hospital was able to borrow money cheaper than the partner was. The financing was changed and done by the hospital, because otherwise the amount of financing would have increased the service costs. This change was possible due to the open designed tender. Thanks to the great results in the first step of the cooperation, the second one was bypassed and the company was immediately established as a PPP.

The biggest issues rose when it came up to the siting of the company. Each mayor wanted the project and the MPAV in his own city. It was no easy task due to the political interest and influence. However, the site was important for the organization of the company. In the original plan, the centralized sterilization was to be built in Feldkirch to reduce the distance for this hospital. During logistics, they found out that the hospital Feldkirch would have only two instead of ten deliveries per day if the company were located elsewhere and therefore the neighbors would be acquitted. This led to a change from central in Feldkirch to central in Vorarlberg. The building is now in Rankweil, right at a highway junction where every of the hospitals can be reached within 20 minutes.

Except of the change of stakeholder to the nurses, the bypassing of the second step and the change in the financing everything went as planned during the project. The state hospitals Feldkirch, Bregenz, Hohenems and Bludenz as well as smaller partners (e.g. care homes) and private orders from companies are included. Since three years the planned size of cleaned instruments

is reached and the profitability given. Further hospitals can be included, but the price cannot be improved too much anymore. Certificates ensure and validate the quality management.

The whole project lasted four years. One year each for planning and the preparation for the tender process, half a year was spent to check and scrutinize and the building phase needed the remaining time. The tight schedule could be met due to a very good organization, a perfect cooperation with politics (building permit, especially conversion of plot for this project) and because nobody put an obstacle in the way.

6.1.2 Management and Leadership

Taken decisions within the triumvirate depend on historical approaches, hospitals and persons. Each of the directors is responsible for his own domain. Information and negotiations take place between directors, when an issue concerns also another area. Since the administrative director is in charge of the budget, he is almost every time involved. At the hospital Feldkirch, the three directors foster an intensive cooperation. Every three years a new medical director is elected (primus inter pares). The better the cooperation, all the better is the hospital led. However, the directors do not only exchange information, they use agreements between them on a collegial basis and on an equal footing for opinion making. Even chief physicians synchronize with the administrative director. Consensus is needed if a decision affects different areas. At the monthly and structured meetings, this unity within the triumvirate is sought and achieved. Important is the open communication on an equal footing and equality of the peers.

Issues and problems may arise when the different viewpoints of physicians and managers are discussed, nonetheless is the morale and atmosphere in the hospital vital. A negative example for a lot of fighting is Germany. In Feldkirch, they are cooperative, but there are also topics with different opinions. Finding common ground and some trade-off with given standards and targets (budget, statutory requirements) is the aim. The open and flexible design of secondary rules is possible within these rules. The cooperation between the employees improves the more they are engaged and comprehend. Many projects are done through quality assurance. To come to a solution, it is important to involve the right people (hierarchies, grey eminence).

Two points are important when it comes to negotiations for projects. First, what do I want? Employee motivation on an equal footing means leadership. Second, never expect to get 100%. It is far better to implement 80% of your plans with the cooperation of all employees than a full implementation without engagement. Willingness to compromise is crucial for finding and implementing a solution that works.

The administrative director does a lot on his own during the creation of each concept. He emphasizes which employees or departments are working on the project. At the beginning, he is intensively engaged (motivator, role model) and delegates responsibility later on, when the project is running. This is his personal style but varies from one to another. The top management always shows interest in projects and walk the floor in the hospital together. Employees are motivated and engaged during projects, because the administrative director built up trust and always gives the opportunity for the staff to contribute their point of views.

Personnel situations (sick leave) are most of the time the reason for a crisis. This issue threatens the operation and the performance of the hospital and is discussed within the top management. All three are involved, because performance means money and the provider are the medical professions. When a conflict appears, they try to hold talks (supervision, motivation and discussions). If this does not work, a task force is used. The administrative director is most of the time the least important, because issues concern physicians or nurses, nonetheless it is expected that he is present too. As the one least involved he does the talking. Each director has to solve an internal conflict on his own. External Experts try to solve physical issues and inter professional or inter departmental conflicts with the attending directors.

If the person is skilled, the professional background is not essential to be a good hospital manager. Physicians can be very good leaders, e.g. chief physicians in the hospital Feldkirch lead up to 150 subordinates. He has to be a good physician to be accepted, though. A trained physician who takes on a management position can do well or not. However, if his peers do not see him as a physician he will lose acceptance and this makes it even harder to fulfill the management position. They may question him to be a good physician, because they can get a bigger salary than hospital managers can. How did he have this vacancy? In the field, it is seen that physi-

cians in management have hard work to cope with their peers. As management expert/business economist, you are in charge of the budget and hence easier accepted, because the physicians don't like this field. As the administrative director, you should be an economist, a lawyer and a psychologist. Therefore, multidisciplinary studies and education is beneficial. A lack in a certain skill can be compensated through some employees. A hospital is a very complex business (different departments, human interrelation with different targets) and unlike corporations in the private sector, you cannot learn in a short time how all the processes work.

A good hospital manager is defined through management and leadership of his staff. Sustainability, reliability, assessability and a clear communication are vital. It is not easy to balance out the entire different stakeholder and their wishes. Scarce resources, patient entitlement to benefits and the powerful and highly efficient medicine have to be reconciled.

The biggest challenge was to get starting. Everyone will experience different aha moments. He is proud when a concrete project was finished and done well. Additionally, that the employee relationships are good and tight so that you really like working together and solve problems. Satisfaction, self-motivation and complacency are very important.

7 CONCLUSION

To sum up, it can be said that the management of hospitals underwent a big change since the late 19th century. It developed from *iatrocacies*, meaning that physicians are in charge and rule (Berg, 2008), towards a more general hospital management. The degree of this development differs between countries. The greatest shift can be seen in countries that have a Beveridge health system. The impact on Bismarck states is far smaller, still using the tripartite structure at the top management level.

An expert interview was chosen and conducted in order to obtain information how the administrative director manages and about the decision making process of the outsourcing of the sterilization. Further on it helped to reconstruct the process of the development of the PPP from the planning until the new established company (MPAV) went into operation.

The data from the elite interview corresponds to a great part with the literature. During the outsourcing of the sterilization it can be seen with many examples that the managerial function are crucial for a successful project. During planning a solid foundation was laid through the thorough search of alternative solutions and some changes were done due to a more beneficial situation, e.g. switching of the financing or relocation of the site. Through the very good preparation and organization of the project the implementation was done almost as planned as in the beginning. A good and open communication, involvement of the staff, picking the motivated employees to support the project, honesty, equal footing between colleagues and building trust are vital points which define the directing and leadership of the subordinates.

It takes some time to learn and develop the essential skills for management, regardless of the trained profession. The author believes that human skills play a crucial role on every manage-

ment level. Even on the top hierarchy where the strategy is defined, managers have to work with other people, no matter if they are just a few. Every employee will watch how the top management acts and behaves with its environment, therefore they are playing a big part as a role model.

When negotiating it is important to know what you want, to be willing to compromise and to involve all the right people. And again, interpersonal relationships are the key for finding a solution, which is acceptable and achievable for everyone.

Like the literature, the interview data state that a hospital is a very complex system. The thoughts of the author are that the professional background does not play a too important role when taking on a managerial position. Nonetheless, it influences the point of views and how issues and problems get approached. The different 'preset' of a manager or physician brings diverse strong suits and faces distinct problems. Yet, as described in section 4.3, p. 23, it needs quite some time and learning to understand the complexity of a hospital. Further on focus should be laid on the skill set and if the person is doing a good job. It came to the authors attention that little attentiveness is given to nurses in managerial positions. Due to their shorter studies compared to the physicians and the management of the interdisciplinary and inter-professional working people at the department they could also be good candidates to take on managerial vacancies.

The PPP project was implemented due to some advantages (section 5.3, p. 28), like the expertise, the problem sharing and the responsibility of the partner. Some disadvantages were solved. Although the distance of the MPAV increased for the hospital Feldkirch, their neighbors faced lesser traffic and the remaining hospitals benefited because of the faster delivery. The complexity of this project was handled very well, still an external lawyer consulted the sophisticated tendering process. Higher service costs were avoided through the change in the funding, which was done in the end by the hospital.

Problems and Limitations

Although results were checked with documents and available information from the homepage (triangulation), it was the only interview. However, the project supervisor was the only one in charge and responsible for the outsourcing and had the greatest as well as deepest insight in the project. This led to the assumption that the crucial information was known and the saturation given.

Expert interviews can give a fruitful and good understanding of special processes, but bear also some disadvantages, which have to be taken into account. The interviewees may mis-state their own position, hence compromising the reliability. They can unconsciously fill out memory gaps to minimize cognitive dissonance or actively manipulate the interviewer by minimizing or maximizing their own role in an event.

The research question and analysis are influenced by the researchers perspectives, for example when coming up with the interview guide. Since this was the first expert interview done by the author, the inexperience led probably to some wrong stated questions. Consequently, this will take some influence on the responses.

The author had no access to some data and documents, e.g. the business plan and presentations for meetings.

Outlook

To bring future physicians, nurses and health care manager together the author hopes that a lively but objective discussion will continue at universities and in the field to answer the question what is needed to be a good manager and drop the issue which profession might be important. Further on the author strongly believes that all three professions have to invest and change to some extend the curriculum. This would lead to an outcome that each profession gets an insight into the other worlds. In practice the professions are also not separated but work together. When working in this direction the understanding, collaboration and cooperation within hospitals will

improve.

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APPENDICES

Appendix A: Interview Guide

Personal information and career path

PPP:

How was the situation before the sterilization got outsourced?

- Which processes were good?
- Which issues and problems were you facing?

Which stakeholder were involved in the decision making process?

Why was the PPP the chosen solution?

- What would have alternatives looked like? (pro and cons)
- Why at this particular time?
- Pros and Cons of PPP?
- Why was SteriLog chosen as partner?
- Why found MPAV as an own company, where KHBG and SteriLog hold shares?

How did the timeline of the project looked like?

What was important to look/be aware of in the preparation phase of the PPP?

- Contract
- Quality assurance

What went very well during the implementation?

Which problems/issues occurred during the project?

- Staff
- Other hospitals
- KHBG
- Partner
- Other stakeholder

Worked the PPP out well?

- Expected benefits achieved/present?

At which expansion stage are you currently standing?

Management/Leadership:

Which decisions can you make on your own?

- Which need the approval of the triumvirate?

How is it to manage physicians, especially senior doctors and head nurses?

- In general (common repeating issues, usual used leverage)
- During decision making process
- While implementing project

How would you describe your communication with your staff as well as with the medical professions?

How do the medical professions (try to) influence the planning process during projects?

How do you handle negotiations in the planning and implementation phase of a project?

- Formal and informal negotiations
- With whom? Which professional groups?

How do you develop common visions/values/goals that every employee comply with?

- Role model?

How do you know when to manage directly or through the administration?

- Which projects or decisions?

- How does this influence the outcome of decisions and the implementation of projects?

How do you handle conflicts and crises?

- During projects
- Common reasons for conflicts
- Physicians bypass top management and go directly to board

What do you think makes someone a good manager/leader within a hospital?
Does the professional background play an important/crucial role when holding a (top) managerial position in a hospital?
Does the professional background play an important/crucial role on the outcome when making decisions?
What were the biggest challenges when you took over and throughout your career in the health care sector, respectively

- How did you accomplished them?

Do you want to add something important, which we didn't mentioned until now?

Appendix B: Consent Form

Consent Form

I, Dipl. KH-BW Harald MALKISCH, MSc agree to participate in Stefan Leitgeb's research study.

The purpose and nature of the study has been explained to me.

I am participating voluntarily.

I give permission for my interview with *Stefan Leitgeb* to be tape-recorded.

I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating.

I understand that I can withdraw permission to use the data within two weeks of the interview, in which case the material will be deleted.

The procedures regarding confidentiality have been clearly explained (e.g. use of names, pseudonyms, anonymisation of data, etc.) to me.

I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

(Please tick one box:)

I agree to quotation/publication of extracts from my interview ☒ – pseudonym !

I do not agree to quotation/publication of extracts from my interview ☐

Signed……. Date 2.5.14